

COMMENTARY

The joys of being a hospitalist

Although somewhat controversial in the United States, inpatient specialists or hospitalists are nothing new in other parts of the world. Residents looking for employment must now consider whether to enter a more conventional practice or declare themselves inpatient or outpatient specialists. This is not an easy task.

As a recent graduate of a traditional internal medicine residency, I also faced this decision. During my training in the managed care environment of northern California, I saw firsthand the burgeoning hospitalist movement. As a resident, I rotated through two hospitals operated by a large, successful health maintenance organization (HMO) and the university hospital where the program is based. In my first year, the physicians at the HMO's hospitals observed their own patients during hospital stays. They went through their rounds before, during, and after their busy clinic days, rushing from one patient to the next so as not to get too far behind schedule. The better doctors took time to talk with the patients, the families, and the residents, all the while seeming less harried. By the time I was a senior resident, both facilities had a hospitalist system in place. I rarely saw any of the primary care physicians in the hospital when their patients were admitted. I did, however, see the "inpatient rounders"—the hospitalists—talking to patients and their families and talking with residents.

My career decision was delayed a year because of my stint as a chief resident. My fellow chief residents and I attended on the wards and in the clinic, adding to our experience and knowledge. Meanwhile, I gathered more impressions of the hospitalist system as it matured at the HMO and elsewhere. I talked with friends who worked in the hospital, those who worked in the outpatient clinic, and those who did both. The advantages of the hospitalist system appeared to be the accessibility of the hospitalized patients to their physicians, increased efficiency of the inpatient service, and the freedom of physicians to manage

their time. The hospitalists were doing what they wanted to do and were generally a happy group. The patients and primary care physicians also appeared to be satisfied with the system. During that year, I enjoyed my time attending on the wards immensely and began to see how dedicated inpatient internists could become an integral part of the academic mission. It became clear to me that I felt much greater satisfaction caring for inpatients than for outpatients.

Through the year, the advantages of observing patients in and out of the hospital also became clear: being able to offer continuity of care, improved communication between caregivers and patients, and having control over patients' care.

Continuity of care is often cited as the major drawback of the hospitalist system. However, patients change their health care insurance frequently, and many lack a primary care physician, so continuity of care seems to be dwindling anyway; hospitalists are a response, rather than a cause.

Communication between physicians and patients, and among physicians, is the cornerstone of patient care. This is especially true with a hospitalist system in place. The lack of control over patients' care is a tougher issue to address, but again, communication is key if a primary care physician is to have a role in the management of an inpatient. As an inpatient physician, I encourage primary care physicians to contribute to our patients' care. These busy physicians appreciate such efforts but will only accept the role of hospitalists when communication is free and open.

In the end, my decision was simple, as I was given the opportunity to start an academic hospitalist program at the university hospital where I had trained. Although we are sometimes looked upon as deficient physicians, I feel we have carved a niche as conscientious physicians and teachers. Had this opportunity not arisen, however, I would have become a hospitalist in the community and would likely have been as satisfied as I am now.

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The hospitalist and the care of the patient

Market-driven forces have dramatically changed the delivery and financing of health services in this country. Among the most controversial departures from traditional practice is the "hospitalist," a new generalist based in hospitals who supplants primary care physicians once their patients have been admitted to a hospital.¹⁻⁴

Conceptually, this program has merits because it addresses the issues of expanding office practice and shrink-

ing hospital load that most generalists now face as the management of more illnesses shifts to the ambulatory setting. Some studies of this model suggest that hospitalists can shorten hospital stays and therefore reduce costs without increasing short-term mortality.⁵ These positive reports should interest the short-term investors in managed care, but what about those with long-term interests—patients and primary care physicians? I am reminded of

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what Francis Peabody said more than 75 years ago: "The secret of caring for the patient is to care for the patient."

As a family physician in a research medical university, I understand my limitations, appreciate the need for subspecialists, and marvel at the wonders of modern biotechnology. For several years, many family physicians have voluntarily referred their patients with acute myocardial infarctions and other critical illnesses to consultants because the data have shown that care delivered by certain specialists is associated with better outcomes. As such, I am not opposed to consultants taking care of patients nor to the growth of new knowledge-driven subspecialties. But the development of this new model appears to be driven primarily by organizational and financial considerations.

A central tenet of family medicine and primary care is continuous, comprehensive, and personal care. It involves a sustained relationship. Although transferring a patient to a consultant improves outcomes for patients with single severe illnesses, what about those patients who crowd our waiting rooms with multiple chronic diseases intertwined with social problems? If it is mandated that patients be handed over once they become acutely ill, that sustained relationship is severed just when patients may need it most. What about the loss of historical information and trust, so vital to care? How will this mandatory hand off affect end-of-life decisions?

If medicine is seen as a commodity, then this turn toward care that is more specialized may be more efficient in the short term. But if medicine is a social good, this reform could drastically interfere with the aspects of clinical decision making that balance a wait-and-see approach based on a long-term knowledge of patients and an aggressive approach based on technology.

It would be foolish to discard the physician-patient relationship as an anachronism. Yet, I am also a realist and can see benefits in this new approach. Accordingly, several

steps should be taken before the hospitalist movement is implemented on any grand scale. First, we need to define what good hospitalists should look like and broaden their perspective to ensure that they think like a primary care physician.⁶ Second, additional studies are needed to measure clinical and interpersonal processes as well as clinical outcomes. This will require sophisticated longitudinal studies that attempt to quantify the value of a sustained partnership and the concept of a therapeutic alliance and trust.^{7,8}

The best approach might involve a voluntary collaborative model in which a primary care physician obtains a mandatory consultation when a patient is admitted to a hospital and then comanages the patient's care with the hospitalist. This shared care could improve aspects of economic decision making while preserving the physician-patient relationship. In the end, should not the final decision to accept the hospitalist's advice rest with the primary care physician and his or her patients as opposed to those whose sole interest is financial?

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AN INVITATION

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